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COMMUNICATION IN MARITAL DYADS COPING WITH BREAST CANCER. PERSPECTIVE OF HUSBANDS PROVIDING INFORMAL CARE

Keywords: informal caregiving, cancer, communication, marital dyad

ABSTRACT

Communication in marital dyads with cancer becomes a source of conflict and unfulfilled needs for all family members if it is superficial and not grounded in a sense of connection. On the other hand, communication be the main way to get out of an impasse and to strengthen the relationship. Previous research has confirmed the significant role of communication between a sick person and his or her informal caregiver in coping with the consequences of illness, but there is still a lack of knowledge regarding communication practices used by married couples experiencing the wife's cancer. This gap arises in particular from the insufficient recognition of the perspective of husbands supporting their ailing wives and, while simultaneously experiencing numerous burdens and difficulties in the face of their wives' illness. The aim of this study was to understand the attitudes towards communication in the marital dyad represented by husbands providing informal care, as well as the types of communication practiced by them during contacts with their sick wives. Interviews were conducted with eight men who were informal caregivers while their wives faced breast cancer, who were active members of a patients' association. The research showed that: 1) taking up and fulfilling the role of a caregiver is a natural consequence of events for interviewed husbands; 2) perception of the wife as a person and as a patient dictates the role of the informal caregiver as either *manager* or *carrier*; 3) two kinds of attitudes towards communication dominated among interviewees: open or avoidant; 4) forms of communication in marital dyads depend on the caregivers' role, including both verbal and non-verbal behaviors. The results may constitute a basis for the development of psychoeducational materials and programs targeted towards informal caregivers of women with cancer, aimed at improving communication between partners in times of illness. Communication is one of the key dimensions of care and support.

1. THEORETICAL FOUNDATIONS

The individual, interpersonal, and social benefits of open communication with other people about an illness from which one is suffering have been shared with patients by numerous sources (cf. e.g. Thompson & Schrodt, 2015, p. 406; Świętochowski, 2016, p. 395). The belief is that making an embarrassing problem public actually relieves the heavier psychological burden of fear of being exposed by others (Kenen et al., 2007; Chaudoir & Fisher, 2010; see also Fujisawa & Hagiwara, 2015). At the same time, such openness can potentially lead to patients gaining more adequate support and better adjusting to their situations (Luszczynska et al., 2007; Manoogian, 2010; Robert et al. 2012; Traa et al., 2014; Galvin et al., 2012; Revenson et al., 2016.)

Female patients suffering from cancer face many difficulties in communicating with those close to them. One reason is the patient's lack of knowledge regarding how their personal illness influences the whole family's life, and becomes a jointly experienced health crisis (e.g., Wiśniewska & Karolska, 2017; Salamon, 2010). Families in which one member has an oncological disease often find that the previously developed homelife routine no longer works, and that established communication patterns are also upset; this is especially true if the previous years of functioning together were mainly based on "covering the silence" (Celińska-Miszczuk & Wiśniewska, 2013, p. 204). Superficial communication within the family, or in the marital dyad, implies the avoidance topics that relate to difficult or unpleasant matters that could hurt someone (de Walden-Gałuszko, 2011; Robbins et al., 2014; Zierkiewicz & Mazurek, 2015). The causes of "communication displacements" are validated either (a) negatively, e.g., feeling shame or fear of emotional expression (Kuijer et al., 2000), the desire to avoid psychological distress (Zhang & Siminoff, 2003; Manne et al., 2006), and withdrawal due to uncertainty about the effects of spoken words (Kuijer et al., 2000); or (b) positively, e.g., desire for "mutual protection" (Zhang & Siminoff, 2003), belief in positive thinking (Zhang & Siminoff, 2003); or (c) neutrally, e.g., indication of gender or place of residence (Hagedoorn et al., 2000; Badr, 2004; Revenson et al., 2005; Ussher & Perz, 2010). The existing communication strategies may suddenly need of urgent adjustment when cancer appears in the family system, bringing with it new needs, vulnerabilities, and challenges.

Research (e.g., Dakof & Taylor, 1990; Bultz et al., 2000; Zhang & Siminoff, 2003; Manne et al., 2006; Badr et al., 2010; Manne et al., 2010; Wierciński, 2015) proves that families dealing with chronic diseases experience many different issues, including communication problems, which – apart from the avoidance of conversation mentioned above – also include excessive formalization of communication, denying worries, concealing fears, not communicating needs and expectations, and more. Disrupted communication, or the lack thereof, can lead to, among other things: the emotional distancing of spouses from one another (Milbury & Badr, 2013; Traa et al., 2014); an increase in the level of perceived stress (Manne et al., 2006; Badr et al., 2010;

Traa et al., 2014); a decrease in satisfaction with marital life (Manne et al., 2006; Badr et al., 2010; Traa et al., 2014); problems in sexual life (Milbury & Badr, 2013); depression (Milbury & Badr, 2013); and psychological changes in the patient (Robbins et al., 2014).

In this context, communication in a dyad in which an oncological disease occurs becomes a source of increasing difficulties if it is superficial and not grounded in a sense of connection; however, paradoxically, it is also the main way to resolve impasses, and even to strengthen and develop the relationship (e.g., Koenig Kellas et al., 2021; Maguire, 2015; Carlson et al., 2000). Usually, people do not scrupulously examine their relationships and do not use metacommunication. "Much of the time, family relationships just *are*! We live them rather than analyze them. The ordinary, routine behaviors of life carry us through each day, usually in a patterned and often unreflective way" (Galvin et al., 2015, p. 120). However, unexpected crisis events, or relational turning points force partners who do not want to give up being together into a trial-and-error learning process, finding new ways of living, and new communication strategies. The most frequently chosen communication tactics – both by patients and their informal caregivers – are those which, intuitively but unfortunately unjustifiably, are considered to have a positive effect on the cohesion of the relationship. These include giving up one's own aspirations to meet the needs of the other party (so-called *self-sacrifice*); displaying friendly reactions even in moments of anger (the so-called *divided self*); and suppressing the expression of thoughts and feelings while perceiving oneself through the role played towards the spouse (*externalized self-perception*) (Ussher, Perz, 2010). Such intuitively selected ways of communicating in a dyad experiencing breast cancer, collectively known as *silencing of the self*, may not bring the spouses the expected results and can burden them mentally (e.g., by causing depression and anxiety). The behaviors that support the relationship are completely different, and include assurances, relational talks, gratitude, openness, and self-disclosure (e.g. Ogolsky & Monk, 2022, 48; Galvin et al., 2015, 122).

Communication processes in the family are analyzed from various theoretical perspectives. Family Communication Patterns Theory (Koerner & Schrodt, 2014; Koerner & Fitzpatrick, 2006) is currently one of the most frequently used in scientific research (cf. Shue & Stamp, 2022), as well as the approach chosen by the authors of this research in order to interpret the results. It derives from the concept of Family Communication Patterns developed in the 1970s by Chaffee, McLeod, and Atkin (1971), which described patterns of communication between family members based on two structural dimensions (originally called socio-oriented and concept-oriented). A more modern version (i.e., Revised Family Communication Patterns) also captures communication processes in the family on two levels, which are now referred to as conversation orientation and conformity orientation. Families in which the first orientation predominates tend to discuss various topics in an open, equal, and inclusive atmosphere. On the other hand, families with conformity orientation – that prefers agreement, structured interpersonal relations, and a clearer hierarchy – are prone to limiting both the number of conversations and the scope of topics discussed in them. Based on these two criteria, four main types of families have been identified: pluralistic (high communication orientation/concept-oriented and less conformism/socio-oriented); protective (high conformism orientation and little communication); consensual (both high communication and conformism orientation); and laissez-faire (with a low orientation to both communication and conformism) (Chaffee et al., 1971; Koerner & Fitzpatrick, 2006). Families in which one of the members is experiencing a chronic disease – depending on the level of intensity of their orientation towards communication and conformism – were assigned model roles of informal caregivers, which are easy to spot while dealing with healthcare professionals: *manager* in consensual families; *partner* in pluralistic ones; *carrier* in protective families; and *loner* in laissez-faire ones (e.g., Wittenberg et al., 2023; Wittenberg et al., 2019). *Manager*-type caregivers strive to take control of the situation and make independent decisions about other family members: in contacts with doctors they often act as the patient's spokesperson. *Partners* from pluralistic families co-experience the treatment and recovery process with the patient, and look after them on mutually agreed terms. *Carriers* are considered to be the group most heavily burdened with the emotional and social costs of giving care, as they conform to the patient's treatment regime in deference to going about their own affairs. People from the last group, *lone* caregivers, remain lonely and confused in the medical situation of their close family; they have no one to ask questions of, do not share their fears, and focus only on the basic, biomedical aspects of helping the sick person (e.g. Goldsmith, 2016; Wittenberg-Lyles et al, 2012a; Wittenberg-Lyles et al., 2012b).

Taking into account the assumptions above, it can be stated that the communication behaviors undertaken by members of families struggling with an oncological disease – in particular the marital dyad (the patient and her caregiver) – differ according to the two dimensions indicated above. Families with a high communication orientation (i.e., consensual and pluralistic) do not avoid difficult topics; however, in those that are also consensual-oriented, there may be no consent to express separate beliefs, and thus the sick or their caregivers (*managers*) lack motivation for self-disclosure (e.g., Miczo et al. 2021, 240–241). On the other hand, members of families with low communication orientation (i.e., protective and laissez-faire) may experience functional difficulties resulting from facing various events and negative emotions alone; meanwhile, those from families characterized by high conformism orientation (protective) can have an additional power imbalance (Miczo et al., 2021, p. 241). In the case of *carrier*-type caregivers, due to partner unresponsiveness, (Miczo et al., 2021, pp. 242–243) topic avoidance may be selective and related primarily to the desire to protect the relationship and, in the case of *lone* caregivers, may be generic, avoiding even topics related to daily activities.

Recognizing the importance of communication in a marital dyad experiencing oncological disease, we wanted to determine the following in our research:

1. What attitude towards communication in the marital dyad is represented by husbands who are also acting as informal caregivers?
2. What types of communication are practiced by husbands acting as informal caregivers in contacts with their sick wives?

2. MATERIALS AND METHODS

2.1. Participants

The participants in the research were husbands of women with breast cancer, who, over the course of a few days, acquired knowledge and skills regarding mutual support at a workshop for couples organized by the "Amazons" Federation of Associations in Poland.[1] Eight men took part in the study. All informal caregivers (10) were invited to the study, but two refused to participate without providing any reason. Men participating in the interviews were aged between 52 and 73. The average age of the participants was 59.2 (*SD* = 7.2). One of the men had acquired higher education, two secondary education, four vocational education, and one primary education. Six were still working, two were retired. Three couples lived in a large city (over 100,000 inhabitants), three in average-sized cities (20,000–100,000), and two in rural areas. The longest marriage duration was 50 years, the shortest 5 years (*M* = 26.7; *SD* = 14.5). All of the participants were parents; the youngest child of the interviewed men was 14 years old, whereas the eldest was 49. The wives of the interviewed men were aged between 46 and 71 (*M* = 54.5; *SD* = 6.9). Six women reported finishing secondary education, and two vocational education. All women were diagnosed with breast cancer. The earliest age of breast cancer onset was 37, the latest 59 (*M* = 49.2; *SD* = 7). Six women had had a mastectomy (of which two had a bilateral mastectomy), and two underwent breast conserving treatment (BCT). Two of those who had mastectomies had undergone breast reconstruction surgery. All women were members of local clubs for patients with breast cancer; their active participation in the clubs had lasted from 2 to 8 years (*M* = 5; *SD* = 2) (Table 1). One of the people interviewed had actively participated in the movement in the USA and later on in Poland.

Table 1
Socio-demographic characteristics of the studied marital dyads

		Number of marital dyads
Marriage duration	Under 10 years	2
	Between 10 and 20 years	-
	Between 20 and 30 years	2
	Above 30 years	4
Children	None	-
	1 child	-
	2 children	4
	3 children	1
	More than 3 children	3

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[1] The Federation is an umbrella organization bringing together approximately 200 clubs spread all around the country (with approximately 25,000 affiliates). It provides, among other things, psychoeducation for breast cancer survivors and, occasionally, for their informal caregivers.

Table 1 cont.

Place of residence	Large city (> 100,000) Medium city/town (20,000–100,000) Small town (< 20,000) Rural area	3 3 0 2
Time since diagnosis	Under 1 year Between 1 year and 5 years Over 5 years	- 4 4

2.2. Procedure

The interview questionnaire comprised of 20 open-ended questions. The questions concerned: life in the marriage before and after the breast cancer diagnosis (relationship, conflicts, duties, intimate life); making meaning of the wife's illness; the husband's emotions after the diagnosis of their partner; the husband's functions in the role of a caregiver (ways of supporting the wife and understanding her expectations); access to professional and unprofessional support for husbands as caregivers; and other related topics.

The interviews were conducted in 2014. All those invited to participate in the research were informed about its purpose, were aware of the research procedure, and knew of the planned publication of the results. All those willing to give interviews were assured of their anonymity and informed that they could authorize the transcript if desired; they then consented to participate in the research. The research concept was ethically accepted by the authorities of the "Amazons" Federation of Associations.

Before the interview, each participant was asked to complete a questionnaire comprising questions regarding demographic data (age, education, professional status, place of residence, marriage length, number of children, seniority of the surveyed women in the Amazons movement) and the course of treatment of the spouse with breast cancer. All interviews were conducted by one researcher (Edyta Zierkiewicz). The interviews were conducted in a room at a holiday center where the workshop for couples took place. The interviews lasted from 45 to 60 minutes. All of the interviews were recorded and transcribed afterwards, and then also transcribed by the second researcher (Emilia Mazurek). Finally, the data analysis was carried out by both researchers.

2.3. Data Analysis

The collected research material was developed using the "thematic analysis" method (Braun & Clarke, 2006). In line with its assumptions, the researchers first familiarized themselves with the data, then coded it; then assigned topics, which were subsequently checked and named; finally, a report was written (Braun & Clarke, 2006).

The meaningful units, most often consisting of 1–3 sentences, were coded. The introductory codes were grouped based on the similarities of the topics they described (Howitt

& Cramer, 2011, p. 339; Boyatzis, 1998, p. 46). The statements of the participating husbands were inductively coded and then grouped. The developing themes, understood as a process of coding the codes, can be treated as "a sort of second level of interpretation" (Howitt & Cramer, 2011, p. 339). For this reason, it is necessary to check whether the topics are based on data, and whether or not they should be divided into sub-topics, or even separate categories (topics) (Howitt & Cramer, 2011, p. 340). The researchers cooperated in the processes of coding, organizing, and creating topics over the course of numerous meetings, both in-person and remote. A similar approach to data analysis was used, among others, by Edwards and Weller (2012).

The outcome of continual comparison of codes and their verification was the creation of four themes; two concerned each of the interlocutors involved in the process of communication during the experience of a chronic disease, and two were linked directly to the communication itself:

1. Taking up and fulfilling the role of a caregiver as a natural consequence of events,
2. Perception of the wife as a person and as a patient,
3. Attitude towards communication in the dyad,
4. Forms of communication in dyads with breast cancer.

The codes making up each topic are presented and described later in the text.

3. RESULTS

The analysis of the collected qualitative data led to the conclusion that the men in the study group were, to a greater or lesser extent, sensitive to the needs of their wives. They expressed it unequivocally in their statements, e.g., about the reasons for their presence at the Amazons workshop. All participants' statements had a great deal in common, e.g. *This is actually for my wife (2); My wife talked me into it. She convinced me (3); My wife said that there was such a thing and that we were going (4), I said: "If you want to go, I will go." That is why we are here (7); She asked me to come. Frankly speaking, I didn't know what it would be, how it would be. In fact, on the way, she told me there would be a workshop. I didn't ask for details. She wanted me to come, so here I am (8).*

This high degree of conformity in the responses of the participating men is a common feature; the only fundamental difference is the intensity of communication with the supported wife – high in some, low in others. As stated earlier, these two dimensions, according to Family Communication Patterns Theory, are the basis for distinguishing types of caregivers. When identifying the typological affiliation of these men, we also used three other categories that emerged as a result of coding the empirical material as being important to understand the way the men functioned in their relationships with their wives: the predominant type of support given to the patient, their assessment of their own efforts in this regard, and the number of people around them who the husbands asked for help if necessary (see Table 2).

Taking into account the above criteria, five participants were classified as *managers* (2, 4, 5, 6 and 7), and three as *carriers* (1, 3 and 8).

Table 2
Typology of informal caregivers

Criteria / Caregiver type	Manager (2, 4, 5, 6, 7)	Carrier (1, 3, 8)
The intensity of conformism	high	
Declared intensity of communication contacts in the dyad	high	low
The main type of support given to the wife	instrumental	emotional
Self-assessment of commitment to care	high	average or low
The number of helpful people around the caregiver	at least 5	3 or less

The differences between the indicated types of caregivers were clearly visible in all four topics that were distinguished in the analysis, i.e., in the course of continual comparison and ordering of codes.

The first topic, **taking up and fulfilling the role of a caregiver as a natural consequence of events**, shows how differently *managers* and *carriers* engage in their duties towards their wives. Before discussing this issue more broadly, it is worth noting that none of the men taking part in the research required an explanation or justification for their wives having breast cancer (e.g., *I don't think there is anything to explain. It happens, just like other disease;* 1-C[2]). They saw it as a fated event (*For me it is just fate or poor luck. It cannot be explained otherwise;* 7-M), a typical life situation (*It is like any other disease. In women it is practically like flu*; 3-C), or a conditioned genetic disorder (*We've had experience, because her sister died of breast cancer at the age of 40.* (…) *You have to live with it, what else can you do?*; 2-M). According to the research participants, their wives' breast cancer could not be grounds for a divorce, e.g.:

> I believe that breast cancer can never be a cause of separation, because it is like any other disease. (…) And what then, everyone would leave because someone is sick? Disease right now…, at this age …, everyone has some weaker points, and something can happen to anybody, and then what? (3-C).
>
> I didn't even think about this [breakup] scenario. I didn't think at all. As for me, it was only important to do everything to heal. And did it go through my mind just to leave? Never in my life! I swore to my wife love, loyalty, and to be there until the end, until the last moment. End of story. And that's how it will be. I'm not going to quit at all. I don't even think about such things (5-M).

Describing the types of *managers* and *carriers* separately, one can point out the characteristic behaviors in the situation of caring for a sick wife (see Table 3). The *manager* – the most common type among studied populations (e.g., Wittenberg et al., 2021) – willingly takes action for the benefit of the patient, and even tends to relieve

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[2] In the text, we use Narrator indications, in which the number denotes the ordinal number of the interview provided by the Narrator, and the letter C / M the type of the caregiver (C – *carrier*, M – *manager*).

her in areas such as making decisions, thus trying to minimize the patient's experience of difficulties (*If I know something can help her, I will do anything*; 7-M). If necessary, the *manager* engages relatives or friends of the family to help, divides tasks between them, and usually discusses various aspects of the patient's well-being with them. Most often, however, he takes the initiative over the course of his wife's recovery (*I was nicknamed "the boss" because I had to be one… Well, what did I have to do? I had to do everything;* 2-M). He willingly participates in the patient's contacts with health service representatives, in which he plays the role – whether asked to or not – of her spokesman, proving, for example, his knowledge of medical jargon and his preparation for this role. The *carrier*, on the other hand, usually acts on his own, taking on any challenge without expecting someone to support him, even when he experiences significant overload. At the same time, however, he does not make choices for the patient and does not impose his opinion on her, but rather follows her decisions without discussing them or other difficult issues (Wittenberg et al., 2017).

Table 3

Codes making up Topic 1 "Taking up and fulfilling the role of a caregiver as a natural consequence of events", both common and those divided according to the type of caregiver.

Codes in the narratives of *managers*	Codes in the narratives of *carriers*
Managing the wife's illness and treatment process (including urging the wife to go for a diagnosis) Taking on the role of a leader or expert Using the help of those closest or organizing a supportive environment for the wife Providing or organizing instrumental support for the wife	Accepting the wife's decision and not urging her (about going for a diagnosis) Independently coping with a health crisis in the family Not seeking support from the wife Not sharing thoughts and emotions with the wife, not blaming her Being close to the wife (providing emotional support)
Codes common in the narratives of *managers* and *carriers*	
Bringing help to the wife or rushing to her aid (imposing help) Voluntarily taking over/doing the wife's duties without being asked to do so Refusing to focus on themselves and their own needs	

The complementary topic to the one discussed above is topic 2, **perceiving the wife as a person and as a patient.** Becoming a caregiver results directly from a serious problem affecting a loved one, e.g., a chronic disease requiring treatment and subsequent rehabilitation, a process which does not end with surgery, and often takes years. The way someone acts as a caregiver is not only an individual matter, it is also related to the way the sick person functions in their role, and/or what they expect from people in their closest social circle. As a result of the mutual interaction of the parties, a specific caring relationship emerges, which, as described by Family Communication Patterns Theory, may be, for example, consensual or protective (see Table 4). In the first case, people are focused on each other (high conformity) and on openly expressing their opinions and showing emotions (high conversation); in the second case, they focus on sensitivity and closeness (high conformity) but avoid unpleasant and “unnecessary” topics or potentially hurtful issues (low conversation) (e.g., Wittenberg et al., 2019). In consensual relationships, patients experience the interest and care of their caregivers (*manager* type), they feel understood and loved, and they are emotionally available and focused on receiving verbal and non-verbal messages, as well as intentional and unconscious messages regarding the wife’s needs.

> While my wife was cooking, I was helping her. For example, when there were larger pots, I moved them or stirred; it depended on what had to be done in the kitchen. I like to help my wife. (…) I just have a wonderful wife (5-M).

In protective-oriented relationships, patients are more withdrawn, secretive, seemingly unmoved by their experiences, and not worried about their ailments and the side effects of treatment. They are somewhat unemotional on a daily basis, focusing all their attention on housework, family, social, and/or professional tasks.

> She appears to be so tough, pretends she doesn’t care, but in fact, there are some emotions. (…) She is not effusive, so what else she expects from me, she will not say. I have to guess (1-C).

Husbands (*carriers*) notice the fragility of their wives and their susceptibility to suffering; they pick up on signs of fatigue and the crisis their wives are experiencing. They also see that their wives do not want to burden them with their doubts or negative emotions, and they admire their partners all the more. The husbands do not want to be a burden to their spouses, even when they are experiencing difficulties or are unable to cope with their own responsibilities and emotions. They deliberately withdraw from conversations about topics that could hurt or upset their wives, and avoid any confrontation, because their goal is to protect the patients’ well-being. For instance, *I knew what my wife’s expectations were. I tried to make it right* (3-C).

Table 4
Codes forming Topic 2 “Perception of the wife as a person and as a patient”, both common and those divided according to the type of caregiver.

Codes in the narratives of *managers* (consensual relationships)	Codes in the narratives of *carriers* (protective relationships)
Reacting to the emotional expressions of the wife Registering the wife’s non-verbal communications about her mental states Noticing the wife’s suffering and showing compassion for her	Guardedness as an important trait of the wife’s character Noticing the wife’s reluctance to talk about difficult topics Noticing the hidden delicacy and emotional sensitivity of the wife Inferences about the explicit need for support, not communicated by the wife

Table 4 cont.

Codes common in the narratives of *managers* and *carriers*
Watching the wife's breakdowns Appreciating the wife's qualities (resourcefulness, allocentrism, mental strength, patience, agency, optimism, her character in general) Noticing an improvement in the well-being of the wife (after completing the treatment, and after joining the Amazons Club with its range of support activities such as exercise programs, massages, talking to psychologists, and, at the outset, sharing the mere information with the freshly diagnosed patient that a considerable group of people are affected by the illness)

As we have already indicated, the analyses show that the husbands approached open communication with their wives differently: they were either willing to undertake it (*managers*; high conversation) or often they tried to avoid it (*carriers*; low conversation). The **attitude to communication in a dyad** is the third theme, based on grouped codes.

The common code that appeared in the narratives of both types of caregivers was that the spouses' conversations were dominated by the issue of the disease and, in particular, the course of its treatment. Although not always, the issues of the detected lump, diagnosis of the disease, and the side effects of oncological procedures were relatively often addressed. Potential breast reconstruction surgery was also discussed in four dyads. At the time of discussions, all four men (1-C; 2-M; 3-C; 6-M) unequivocally dismissed their own needs in this regard (sexual, aesthetic) and believed that their wives should not undergo breast reconstruction; however, it is important to note that they communicated it differently – *carriers* followed their wives' leads while *managers* strongly emphasized their own negative position, e.g.:

> She said she would not undergo [the reconstruction surgery]. I also find it unnecessary. Why would she have to undergo so much pain, so many different procedures and operations…? Just so I can look at her breasts? It doesn't make (…) any sense to me (3-C).

> I don't mind. I wouldn't even let her… What for? I don't mind. It is also a risk. And the pain, that's all. Some mad man would require it of his wife. It doesn't bother me (6-M).

Other conversations, conducted quite openly in both types of families (though more often in consensual rather than protective relationships), also concerned the disease, in a sense, because the *quasi*-social aspect of the disease, i.e., breast cancer incidences among family members (mother, sister) or among friends, was discussed.

Apart from the descriptions suggesting an open approach to communication (three common codes), the narratives of the men showed fragments that indicated deliberate avoidance of certain matters to a greater or lesser extent (two common codes; Table 5). The husbands' statements called attention to the fact that their wives did not openly express their expectations, and the men were therefore forced to guess them. The participants also described incidents of sudden breakdown in their partners, just after receiving the diagnosis of cancer, when they fell into panic and fear, cried desperately, or began thinking about death. At such moments, the only thing that made sense to the men was to comfort and reassure their wives, e.g., *She said I would be at her funeral. I told her it would be okay. That's how I supported her* (4-M).

In general, it can be said that in consensual families, people talk more often and on many more topics than in protective families – both before the diagnosis of cancer (e.g., *I mobilized her to do so. I said, "Go get tested." She: "No, no" (...) I said: "The examinations are free.*" *And she applied*; 6-M), as well as during the treatment (e.g., about difficult emotions experienced in times of crisis), and after the end of the treatment (e.g., about the wife's social activity in the Amazons Club). Caregivers of the *manager* type indicated that there are practically no taboo subjects in their relationships. For them, communication is a strong bond within relationships; failure to talk is very rare, and relates to traumatic events (speechlessness as a result of shock after receiving the diagnosis) or exceptional circumstances (the inability of wives from more traditional families to express their expectations).

It can be concluded from the narrative of *carriers* that the spouses do not talk to each other on as many topics, starting from the lack of detailed discussion about the course of treatment (e.g*., I found out about it after the surgery. (...) I came to her hospital after the surgery, and she said, "I don't have a breast." (...) I knew she was going for a biopsy, but instead, it was this... She had a cyst before and thought it was a cyst. I was speechless*; 1-C); through not asking how their wife deals with emotions during medical procedures (e.g., *She was attending meetings with a psychologist the whole summer. She was sitting there all day long. I think it helped her a lot*; 3-C); to not caring about the involvement in the Amazons movement. Keeping conversations to a minimum arose mainly from the desire to protect the wife's well-being, and to not upset her or arouse fear. For example, the opinions of one of the participants (8-C) often differed from his wife's – for example, about changing their place of residence, about the cause of her cancer, about attending the Amazons workshop, and other matters – but he intentionally did not show it and usually agreed with his wife's decisions. All *carriers* stated that they would rather take action with or on behalf of their partner than talk about cancer and its impact on family life, because that makes them start thinking about the disease, which leads to feelings of fear and hopelessness.

Table 5

Codes making up Topic 3 "Attitude towards communication in a dyad", both common and those divided according to the type of caregiver.

Codes in the narratives of *managers* (open approach to conversations)	Codes in the narratives of *carriers* (avoidance of conversations)
Talking to the wife about the need to take care of her health (screening tests, diagnosis)	Not sharing information with the husband about planned cancer treatment
Talking about the wife's difficult emotions and breakdowns	No talks about how the wife is coping with the disease

Table 5 cont.

Experiencing difficult emotions together Choosing appropriate responses to the wife's identified needs (toning down her emotions through relaxing conversations or by waiting silently) Talking in order to come to terms with the topic of cancer Conducting instructional conversations (during post-treatment care activities, while massaging the hand) Talking about the wife's work in the context of its burden on her health Talking about the difficult situation of patients in the health service in the context of treating his wife Talking about the wife's social activity	No conversations about the patient's emotions; the need to guess what the wife is going through Each partner separately experiencing difficult emotions Not talking about the wife's reactions to treatment (inference from observation) Doing something (together or separately) instead of talking (and thinking) about the illness Maintaining the status quo silently – not letting cancer change the family's way of life Joking together about the side effects of the disease (hair loss) Minimizing discussion of the wife's social activity Lack of knowledge about the wife's assessment of the husband's role as a caregiver
Codes common in the narratives of *managers* and *carriers*	
Talking about the medical aspects of the disease Talking about breast reconstruction; presenting the wife with a negative opinion about the surgery Talking about other cases of illness (in the family and/or among friends) No conversations about the wife's expectations (the need to guess them) Reacting to the wife's breakdown by comforting her	

The fourth and final topic which we have distinguished adds more detail to the ones discussed above. **The forms of communication in a dyad with breast cancer** include both verbal and non-verbal means of communication indicated by the informal caregivers. The similarity of non-verbal behavior between *carriers* and *managers* occurs in relation to: taking care of the wife; looking after her and the so-called indulging in the illness (e.g., providing her with loving care); rushing to her with help; getting used to a difficult situation and anxiety that lasts for many years (e.g., coming to terms with her illness); not thinking about departing from the wife; remaining optimistic and not allowing negative thoughts (e.g., resignation) to become prevalent; and deepening the marital bond by participating in activities that are attractive to both partners (joint trips, excursions, visiting family, meetings with friends, going dancing, and going to the theatre). With regard to verbal behavior, there was only one similarity: comforting the wife (convincing her that everything would be fine) (Table 6).

The analysis shows that *carriers* preferred to show commitment and care through non-verbal signals (this covered 10 codes, compared to 3 codes relating to forms of verbal communication), while *managers* used forms of verbal communication slightly more often, but did not give up on showing concern in a direct way (18 codes to 12).

Table 6
Codes forming Topic 4 "Forms of communication in breast cancer dyads", both common and those divided according to the type of caregiver.

Codes in the narratives of *managers*	Codes in the narratives of *carriers*
Non-verbal behavior – looking after the wife (so that she would not hurt herself by doing household chores and not asking for help) – doing various housework for the wife – learning how to properly care for the wife (hand massage) – unexpected support from the wife – bringing the wife to Amazons Club meetings and rehabilitation, positive response to wife's requests – accompanying the wife at every stage of the treatment process – distracting the wife from thinking about cancer – leading a fun and relaxed life – making sure of the quality of medical care for the wife – learning from each other in a new stage of life – feeling supported (spiritually) by the wife	Non-verbal behavior – being close – following the wife – presenting an accepting attitude, – satisfying the (guessed) needs of the wife – supporting the wife in recovering – not breaking down – not looking for support for himself – giving up his own needs for the sake of meeting the wife's needs – not avoiding the problems – searching for and implementing solutions
Verbal behavior – resisting the wife's defeatism – convincing the wife that "cancer is not a death sentence" – dissuading the wife from undergoing reconstruction – explaining to the wife that not having a breast will not change the relationship – inducing or forcing the wife to undergo screening tests – confiding feelings and emotions in each other – supporting each other with warm words – constant exchange of information and emotions, constant contact (e.g., very frequent phone calls) – encouraging and mobilizing the wife to undertake activities in the Amazons Club – advising the wife about social activism – sharing one's own experience of social activism – frequent use of humor – reassuring the wife that what's good for her is good for him too – keeping the wife in good spirits – receiving instructions from the wife regarding help in postoperative care and massage	Verbal behavior – declaring the availability of aid – assuring the wife that they will cope as a couple – joking only occasionally (i.e., about the side effects of the disease)

Table 6 cont.

– receiving praise from the wife for exceptional care for her – being a calming influence – intentional silence	
Codes common in the narratives of *managers* and *carriers*	
Non-verbal behavior – Caring about the wife – Taking care of an ailing wife – Failing to help the wife – Coming to terms with the wife’s illness – Not thinking about leaving a sick wife – Not giving in to doubt – Deepening the relationship with the wife by participating in shared activities (social, family, sports, etc.) Verbal behavior – Comforting the wife in times of breakdown	

4. CONCLUSION AND IMPLICATIONS

Communication plays a very important role in building and sustaining any family, but it seems even more significant in those with an oncological disease. Certainly, the thematic scope of communications changes or expands – with the introduction of issues previously overlooked or omitted as they did not relate to the family system. A family member receiving a cancer diagnosis and undergoing subsequent treatment leads to major changes (e.g., in terms of dividing the chores) that need to be communicated within the group. It should be noted, however, that the intensity and frequency of family conversations is not determined by the disease, but depends on the attitudes and beliefs of its members. According to the Family Communication Patterns Theory (Koerner & Fitzpatrick, 2006), contacts among one’s closest circle are regulated, unintentionally, through two orientations: high or low conformism and high or low communication. During the illness and afterwards, communication patterns are unlikely to change dramatically, unless family members engage in metacommunication (i.e., talking about a conversation) and then consciously and more or less openly initiate a new type of interaction.

This research looked for answers to two questions: about the attitudes of husbands who are also informal caregivers to wives suffering from breast cancer, and about the forms of communication between spouses. All participants were characterized by a high degree of submission to their wives (conformist orientation), but the need for open communication differed – some felt it, and actioned it constantly (*managers*), while others (*carriers*) only did so when it was, in their opinion, necessary or inevitable, more often using non-verbal strategies to strengthen bonds with wives. The main conclusion from our analyses is the observation that, in the case of the men who participated in the research, their high orientation towards conformism (including “wife orientation” and the desire to act for her) was the basic condition for forming relationships with sick wives. The question of the participants' approach to communication in the dyad seems to be slightly less important, or rather perhaps conditioned by their previous attitudes – both direct (open, sincere, intense) and indirect interactions (withdrawn, somewhat guarded, especially in relation to "difficult" topics) were characterized by tenderness, attentiveness, and care towards their wives. This does not mean, however, that communication does not matter. In fact, the participants did not take communication for granted; for them it was the bond of the relationship and the key platform of contact, although they expressed this differently. Moreover, our research shows that entering the role of an informal caregiver – or rather, the way that husbands approached this role – was associated with the observations their wives made during the period of cancer diagnosis and treatment and, in general, with the husbands' beliefs about their wives (e.g., their character or needs), as well as with interactions preceding the critical event, such as the emergence of the disease in the family. The last conclusion that we formulated based on the analyzed empirical material is the observation that informal caregivers with a high degree of communication (*managers*) not only talked about more topics than the *carriers* did, but they also engaged in a greater number of interactions with wives by expressing non-verbal affection and caring for them.

The types of informal caregivers, originally identified within medical institutions (e.g., Wittenberg et al., 2021), make it possible to understand how families with oncological disease are functioning, i.e., how they are communicating. The model developed by Wittenberg and colleagues (2021) for a different "communication environment" has proved to be useful for studying communication in dyads with breast cancer occurrences, but more research and in-depth analysis are needed to confirm our findings.

It should be emphasized that the men who participated in our research form quite a specific group because they are the husbands of active members of the patients' association. One of the key social activities with a clearly proven positive impact on the psychophysical well-being of patients is membership in grassroots organizations(e.g., Hegelson, 2011; Harrington et. Al., 2012). The husbands not only accept the activism of their wives in patients' organizations, but also engage in the work (and entertainment) of women's breast cancer associations to a greater or lesser extent. A manifestation of this attachment to their wives was their presence at a workshop for couples organized by the "Amazons" Federation of Associations, during which the interviews were conducted. Due to this, and to the very small group of participants, our results cannot be generalized or assumed to be true among more diverse populations (i.e., in the population of people who do not benefit from psychological help or do not participate in support groups); hence further research is needed.

Declaration of Conflicting Interests

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Komunikacja w diadach małżeńskich zmagających się z rakiem piersi. Perspektywa mężów zapewniających nieformalną opiekę

Słowa kluczowe: nieformalna opieka, rak, komunikacja, diada małżeńska

STRESZCZENIE

Komunikacja w diadach małżeńskich, w których jedna z osób choruje na nowotwór staje się źródłem konfliktów i niezaspokojonych potrzeb wszystkich członków rodziny, jeśli jest powierzchowna i nie opiera się na poczuciu więzi. Z drugiej strony komunikacja może być głównym sposobem na wyjście z impasu i wzmocnienie relacji. Dotychczas przeprowadzone badania potwierdziły znaczącą rolę komunikacji pomiędzy osobą chorą a jej nieformalnym opiekunem w radzeniu sobie z konsekwencjami utraty zdrowia, ale nadal brakuje wiedzy na temat praktyk komunikacyjnych stosowanych w parach małżeńskich doświadczających choroby nowotworowej żony. Luka ta w szczególności wynika z niedostatecznego rozpoznania perspektywy mężów wspierających swoje niedomagające żony, a jednocześnie także doświadczających licznych obciążeń i trudności w obliczu choroby żony. Celem badań było dowiedzenie się, jakie postawy wobec komunikacji w diadzie małżeńskiej reprezentują mężowie-opiekunowie nieformalni oraz jakie rodzaje komunikacji praktykują w kontaktach z chorymi żonami. Przeprowadzono wywiady z ośmioma mężczyznami pełniącymi rolę nieformalnych opiekunów swoich żon chorych na raka piersi, aktywnych członkiń stowarzyszenia pacjenckiego. Badanie wykazało, że: 1) podejmowanie i pełnienie roli opiekuna jest dla badanych mężów naturalną konsekwencją zdarzeń; 2) postrzeganie żony jako osoby i jako pacjentki wpływa na rolę nieformalnego opiekuna: *menedżera* lub *obrońcy*; 3) wśród badanych dominowały dwa rodzaje postaw wobec komunikacji: otwarta lub unikająca; 4) formy komunikacji w diadach małżeńskich zależą od praktykowanego typu roli opiekunów, obejmują zarówno zachowania werbalne, jak i niewerbalne. Uzyskane rezultaty mogą stanowić podstawę opracowania psychoedukacyjnych materiałów i programów skierowanych do nieformalnych opiekunów kobiet chorych onkologicznie, mających na celu poprawę komunikowania się par w sytuacji niedomagania somatycznego. Komunikacja jest bowiem jednym z kluczowych wymiarów opieki i wsparcia.